AZ Medicaid Outpatient Workgroup Meeting

June 2, 2004
1:30 PM to 3:30 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: Sara Harper, AHCCCS

Facilitator: Lori Petre, AHCCCS

Attendees:

(Based on sign-in sheet)

ADHS	**CMDP**	***Kathy Steiner***
Jerri Gray	***Felicana Rincon***	***Jean Warner***
AHCCCS	***Amanda Worth***	
Howard Beam	**DES**	
Barbara Butler	***Robin Claus***	
Melonie Carnegie	***Adian Frazier***	
Cia Fruitman	***Marcella Gonzalez***	
Susan Goldsmith	***Major Williams***	
Sara Harper	**Evercare**	
Dora Lambert	***Steven Iles***	
Lori Petre	***Vicki Johnson***	
Kari Price	**Healthchoice AZ**	
Brent Ratterree	***Jessica Linnick***	
Mark Renkel	***Lori Owens***	
Lydia Ruiz	***Kathy Thurman***	
Brian Skjordal	***Joan Toland***	
Mike Upchurch	***Mike Uchrin***	
Americhoice	**MCP/Schaller Anderson**	
Karen Gaskill	***Terry Linney***	
Brenda Reininger	***Wendy Lytle***	
Vanessa Wright	***Anne Romer***	
APIPA	**PHP**	
Alexia Cathers	***Greg Lucas***	
Chuck Revenew	**PHS**	
Sharon Zamora	***Marcia LeBlanc***	
Care 1st	**UFC**	
Anna Castenda	***Kathleen Oestreich***	

Current Status/Timeline (Lori Petre)

We are going to go ahead and get started. Everyone should have a package. We made extra today, as last time several of you wanted some to take back with you. Included are minutes from the 5/12/04 Outpatient Workgroup meeting. We are working on the structure of how we are going to post these to the website. I will let you know in the form of an email once we get that worked out. We did want to get you a hard copy of the minutes. In reviewing the minutes, if you have any questions or comments, do let us know. This is the permanent record of these meetings so it is important that the information contained is accurate.

Action Item: Lori Petre
Email the workgroup with where on the website the Outpatient Workgroup meeting minutes can be found.

The second thing in the package is the revised Outpatient Hospital Capped Fee Schedule Project Timeline. This is what I promised you the last time, that I would take the timeline that we had established, and we would go back and revisit it based upon the 7/1/05 implementation date rather than the 1/1/05. In that the timeline has shifted, the first change you will see is that we have opened Requirements back up for a short period of time just because we had the extra time. We wanted to make sure that we appropriately capture everything up front so that we would not have to institute the Change Management process yet. That is due to complete on 6/15/04. We will have final Requirements documents, and I following that up no later than 7/1/04. If at all possible, we will try and bring that final Requirements document with us to the meeting on 6/23/04 so you will have the most current information. The System Proposal basically follows about three weeks after we finalize the Requirements document. It is hard to come up with an exact date on that because the finalization of our requirements does necessitate that we have signatures from some of the key stakeholders, and sometimes it takes a little longer, especially this time of year with vacations. We tried to come up with more of a window. In all cases, anytime we can shorten these at all, we will certainly do so. These are our latest date when we would like to make these things available. We will finalize the System Proposal two weeks after the draft has been sent for review.

The other thing that Sara and I did, was schedule out the Outpatient Workgroup meetings through 09/04, at which point we will look at them again. I have not sent out the meeting invitations for these yet; I need to put them on the calendar. We went ahead and left them at the 3-week increments; we will revisit that if necessary.

These are the dates as they currently stand. Also, Kari Price in the CEO meeting last week shared this timeline. System Development immediately follows the finalization of the design, and we show a 90 day window for that. If at any point we can compact that window a little bit, we will do so. System Integration Testing is scheduled to immediately follow development, and we are targeting 60 days for that. Pilot Testing with hospitals and interested health plans we hope to begin no later than 1/1/05, and we allowed 2 months for that. If you are interested in being a pilot tester, do let us know. We will certainly try to accommodate as many of those pilot test requests as possible. User Acceptance Testing and Trading Partner Testing with all hospitals and health plans has an open window from 3/1/04 through 6/30/05. It is hard to believe that we are all ready looking at next year! We try to allow a big window for open entry open exit, as you are ready. If you want to test for a couple of weeks, go back to look at things, and then start testing again, you can do so. We are targeting actually have all the table verified, updated, and in place for 6/1/05 so that you will get to see those new table structures going out to you in your 6/1/05 reference file extract. All the remaining components we will promote on 7/1/05.

Project Email Address (Lori Petre)

We got the Outpatient Workgroup email address setup. The next thing in your package is just a reminder that it is out there. If you have questions, comments, or suggestions on examples, please submit those to the Outpatient Workgroup. Melonie and Dora will be monitoring that and will be getting responses out.

Processing Flowchart – Current Version (Lori Petre)

The next document is the Processing Flowchart, which I have told you several times that it is just draft work in progress. We try and take your feedback from these meetings and other meetings, and try to refine this. What we did was take the feedback from the 5/12/04 Outpatient Workgroup meeting, and turned it into a front and back flowchart rather than one single flowchart. It does divide the editing from the pricing processes. Please take a look at this. We did not change a great deal in the actual meat of the flowchart other than to put in some clarifications of the filter, new tables, some of those types of things that you had asked about in the last meeting. If you do have questions about this as you find time to review it, if you have other suggestions, if something still is not working for you're the way it is presented, do let us know.

Processing Examples

Updates From Last Meeting (Lori Petre)

The next package we are not going to walk through. These are the 5 examples that we looked at in the last meeting. You had some comments and questions so I went back and incorporated those revisions into these 5 examples. If I missed anything, or you have questions, comments, suggestions, please let us know.

Sara Harper – The changes that we made were primarily adding revenue codes and changing some of those, and to explain the filter applied to the different bill type claims.

The next handout is a copy of an email from Cia Fruitman to me. On the back of that is a list of revenue codes. Please disregard the second page that came with that email; Sara indicated it was not something that was relevant so you may toss the second sheet of that handout. That was something that was more explanatory for the hospitals from the presentation. After the last meeting, we did get a question about which procedure codes we are using at this point to designate emergency room (ER) and which procedure codes we are using to designate surgery. Within the email itself, it tells you the procedure codes currently defined for ER and Cia is working on those that designate surgery. We will share those with you just as soon as we have them.

Action Item: Lori Petre
Share the procedure codes designated for surgery with the Outpatient Workgroup.

The second question asked us for which revenue codes get bundled under ER. That is what the list is that is on the back. Those were two of the items that we did have a request for after the last meeting. If you have any questions about this, or there are other items you would like to see again, please let us know by emailing the Outpatient Workgroup so that we can track and make sure we get a response to you.

System Requirements Status/Table Layouts

Table Layouts (Lori Petre/Mike Upchurch)

Lori Petre - The other request we had from the last meeting was that we share the draft table layouts of the new reference tables so that you can begin to get a feel for what they are going to look like. That is what this next package is. Mike, did you want to talk a little bit about what John Murray did?

Mike Upchurch – John Murray is not at this meeting today, and for that I apologize. Basically, you all ready receive specific files every month that you bring into your system. All we are going to do is update those reference files, make sure that you get current bundle drivers, make sure that you have all the information that you need to operate your systems to correspond with what AHCCCS is looking for. There has been one new file added. It will include the revenue codes, the procedure coding, and the different indicators that we are currently working on to identify the process. You will receive the same reference files that you are currently receiving; nothing will change on that. This will just be an additional file that you will get on a monthly basis.

Q: When will it be out there?
A: At this point, we are still waiting to finalize everything that is going to be used. We recently moved to putting the reference files up twice a month on the 1st and the 15th. It will be in conjunction with the other reference files that you are receiving.
Lori Petre – The first time you see it will be 1/1/05 during your production files. During the external testing window, and probably during the pilot, also, we will be putting those files out there so that you will have them available to you.
Mike Upchurch – If we make any changes to those files in test, we will let you know in advance what those changes will be. We will put a new file out there so that you can pull it in and use it.

Lori Petre – Once you go back and take a look at these, if you have any questions, please email the Outpatient Workgroup. John did not include any of the tables that you are all ready getting under the assumption that you had those. These are tables are as the requirements currently stand, and we stress that this document is in Draft format only. We did so to make sure that no one started development based upon something that we were not quite sure on. This will be part of the Requirements document, so when you do get the Requirements document, it will contain the final table layouts.

System Requirements (Lori Petre)

The other change that we made was in regards to requirements from what we had originally discussed. We originally discussed, in the very first group, and I realize that there was a much smaller of number of us in attendance at that meeting, that there would be a Claims Requirements document and System Proposal, and that there would be an Encounter Requirements document and System Proposal. We also chose to separate out the Provider and Reference. There will actually be 3 documents, as Provider and Reference will have its own unique document that works interactively with the others. We will actually have 3 documents we will be sharing with you for Requirements documents and 3 System Proposals.

Q: Will all of this be out on the website?
A: One of the things that we are looking at doing is actually taking our concept of the HIPAA website and making it more of a Technical Information website with separate buttons under that. Doing things like the Outpatient information through there, and making it something so that we can continue to apply the concept regardless of the type of project. HIPAA never goes away, but it is going to eventually become an incremental type of thing. We will probably, in all likely hood, and Melonie and I just had an initial conversation on this last week, be renaming that website and handling it a little bit differently. The intent is to provide an Outpatient structure there. We do maintain all of the soft copies in the Library so we will be putting everything out there just like we

do for HIPAA. We just need to really restructure the website to make it more universally applied. We will be working on that. In the meantime, if you need a soft copy of something that we have handed out, send the Outpatient Workgroup an email, and we will make sure we get it out to you.

New Examples

Lori Petre - The next thing that we are going to go through is actually at the back of your package as I was late in getting it to our copiers. Basically these are 10 new examples. What I did was pull 10 AHCCCS production claims. I pulled from 6 different hospitals, and I tried to pull randomly. Some of these have a lot of revenue codes, some have a few, but these are 10 to start us with. After reviewing these, we can discuss a little bit about what additional examples you would like to see, and we will try to target some of those types for the next meeting. The other thing that Sara Harper and I talked about was maybe for the examples in the next meeting we would both present the decisions as a spreadsheet and a physical claim that showed what the claim itself would look like.

Example Review (Cia Fruitman)

The examples show all the different decision paths that would be on the chart that we gave you, and they are fairly straightforward. We will review these examples, and if you look back on the ones that we do not get to, and you have questions, you can email those questions to the Outpatient Workgroup.

Example #1

The 1st example is basically a series of labs and observation room. There is one unit of each. Remember that these are draft prices so the actual values are subject to change. The current unit price we have, for instance, for comprehensive metabolic panel is $23.98. We are just applying its fee schedule rate per unit. That is the same for all 4 of these labs. Then, for the observation we do not have rates for observation, so this is going to go against the CCR. That would be $175 x .3175, which is roughly the CCR right now, and it comes out to $55.56. The total is $122.00 for this example.

Q: This is not an ER surgery so if a claim comes in without the CPT or HCPC, will AHCCCS reject it if they just have it submitted with the revenue code?
A: We are still working out what is required. There is an edit table that shows procedure code to revenue code, and where it is required to have a procedure code for the revenue code and where it is optional. For the lab revenue codes the procedure code will be required, so there would not be a lab without a procedure code or the encounter will pend. It will be required per the edit tables.

Q: Even when it is not an ER surgery?
A: Right. There are some revenue codes where it is optional. For instance, pharmacy, sometimes you have it, sometimes you don't. Supplies, sometimes it is a specific code, sometimes it is not. It is an optional code there so that line will process with or without a procedure code. What will happen is that before you ever get to the pricing, the encounter will pend because of the edit table. The edit table is an existing table; it is just that there will be more information in it. I believe that is the RF773 Revenue Codes-To-Procedure Codes table.
Brent Ratterree – A lot of encounters are passing through those rudimentary procedure codes all ready as well as passing through certain revenue codes.

Q: These prices all refer to the HCPCS codes, right?
A: Yes, the first four prices on this example would be on the fee schedule by HCPCS code. The observation does not have a fee schedule price at this time so that would be CCR.
Sara Harper – However, in the future, if they should get a rate, we will put it in.
Cia Fruitman - This is where it goes down through the flowchart asking if this is bundled. No, so it goes outside that whole bundled loop for all of this, and then you go to the fee schedule;

everything that is on the fee schedule is priced. If it is not on the fee schedule, it pays CCR, which is the statewide CCR one size fits all. Hospitals will no longer have their own specific CCRs, because a default CCR is going to be calculated for just those services that, for one reason or another, we could not price out.

Example #2
The 2nd example is a real easy one. It is an ER Level 1 visit that pays $79.39. The drugs are bundled into the ER visit so that line pays $0.00.

Example #3
The 3rd example is a good one because I think it will clear up a little bit of confusion from last time. Again, you have an ER Level 2 visit, and it pays $137.14. The pharmacy is bundled in with it, so it pays $0.00. There is a second ER code there for therapeutic prophylactic injection. That pays the fee because ER's do not bundle in with each other; the 45X is not on the bundled revenue code list, so it will be paid. The code 730 for the EKG is also not on the bundled list of revenue codes, so it will be paid the fee schedule amount also.

Example #4
The 4th example is easy. It is just an ER visit, which is going to pay the ER rate. Nothing else was attached.

Example #5
With the 5th example, we get into a little bit more detail. This is an example of the earlier question about procedure code. The first three revenue codes here do not require a procedure code. However, there is an ER visit, so all of the first three will pay $0.00 for those lines because they are bundled into the ER visit. All of the labs, 9 altogether, will pay off the fee schedule because they have a rate associated with them. Ultrasound will also pay off the fee schedule because it is not on the bundled revenue code list. The 51702 ER code will pay off the fee schedule. Except, at the moment, we do not have a rate for that one, so it went to CCR. At the time we set the rates, we probably did not have enough services.

Q: Those would be by report procedures?
A: Yes, the CCR works just like by report except that instead of 65%l, it will be whatever the statewide CCR is, which right now we are estimating at .3175.

There is an injection that is going to pay off the fee schedule. Then you have a level 3 ER visit, and the rate for that is $226.00. The last 3 injections use the rates of the injections right now. Injections on the fee schedule for hospitals will match the physician fee schedule rates on the theory of a drug is a drug, regardless of where you get it.

Example #6
The 6th example is pretty much the same sort of example as the previous one, except that nothing is bundled on this one; there were no bundled services charged. Everything pays off the fee schedule. If you go down to line #8, there is an example where you are just taking the 43.65, and multiplying out by the 2 units.

Example #7
The 7th example is like the 5th example but much shorter. Again, you have 2 bundled services. At the moment, we do not have a rate for G0001 so that is paying CCR. Everything else is paying fee schedule.

Example #8
The 8th example contains miscellaneous supplies. There is no bundling here. It is miscellaneous, and because there is no specific rate included, it uses the CCR. There is no procedure code to base the rate on. For the treatment room, again there is no specific code associated with it, so that one is CCR. The fetal non-stress test is $114.39. Just as an aside, which is probably pretty obvious, on the treatment room there are two units, which does not matter in this case because it pays CCR so units do not apply.

Example #9
The 9th example is for Urgent Care, but if you look at the code, it is a 99203, which is not a code that bundles. The pharmacy is going to pay CCR, and then this is going to pay the 99203 clinic visit rate even though it is with the Urgent Care revenue code.

Q: On this example, there is a revenue code of 250, but we would not have that priced in the fee schedule, right?
A: The would be the CCR.

Example #10
The 10th example, you have ultrasound on the fee schedule. The treatment room has no code again so it is going to pay the CCR. The fetal non-stress test is going to pay off of the fee schedule.

Sara Harper – As we said, if there are specific examples that you would like to see, please email them to the Outpatient Workgroup. We would like to provide you with examples that are useful to you. For these examples we went through the claims system and tried to pick a little bit of everything, different hospitals, etc. If there are some specific examples that you are seeing on the encounter side that we may not have picked up looking at claims, please feel free to provide us with these examples.

Wrap-up (Lori Petre)

There are two things left in the package. I have enclosed a copy of the distribution list as it we currently have it for the Outpatient Workgroup. Please take a look at this and let us know if there is anyone missing, and we will make sure to update. The last thing is a survey that Sara and I worked up that I actually sent out yesterday. I do thank those health plans that have all ready sent us a response. We would like to get a response from all the health plans by COB Friday. We will be summarizing these surveys and having an internal meeting to decide how we would like to utilize the information and share the results with all of you. It is real important that we get the survey back as your input is critical. We do not want to make assumptions that things are easy for you. If you did not see this survey, please let me know. Sara, did you have anything else you would like to add?

Sara Harper – At the last meeting I passed out the latest implementation information. At the CEO meeting last week we did pass out the Senate Bill 1410, which defines this whole process. For the interim period of 7/1/04 through 7/1/05 on a hospital-by-hospital basis, AHCCCS will be monitoring charge master increases for existing outpatient hospital services for each of the hospitals. Each time they go over the 4.7% increase limit for existing outpatient hospital services, we will take that portion above and apply it negatively to the CCR. Each hospital is limited to one outpatient adjustment between 7/1/04 and 7/1/05, so that we are not chasing moving targets too badly! Right now we are working with ADHS to get the information from them on hospitals that are changing their outpatient charges. The change for you will be if you use AHCCCS fee-for-service CCR in your payment methodology. It would then impact payment so you would have to adjust CCRs on a hospital-specific basis.

Q: We have 17 hospitals scheduled for a rate increases effective 7/1/04 so will you have time to get that information out to us in the next few weeks?

A: Yes, and there will also be the standard outpatient CCR update on 10/1/05.

Q: Will you be able to let us know the winners and losers in the hospital mix?
A: Kari Price – We are really far away from that.

Q: Do you know what 17 hospitals are updating in July?
A: We will give that information out. We are currently working internally for the best way to do that.

Q: Kari Price – Once we have identified the hospitals that did go over the 4.7% outpatient limit, if we get that list out to you, will that be helpful?
A: Health Plans – Yes.

Next Meeting (Lori Petre)

The next meeting is scheduled for 6/23/04 after the Consortium meeting. I will get these future meetings scheduled out.

Action Item: Lori Petre
Get the future Outpatient Workgroup meetings scheduled.

Sara Harper – We do apologize that this meeting did not take the full two hours that we had blocked for it. We were basing the need for a longer meeting on our last meeting where we did not allow enough time. We do appreciate your flexibility while we try to establish an appropriate timeframe.

Meeting adjourned at 2:15 p.m.